Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

NATIONAL QUALITY MEASURES CLEARINGHOUSE

# General

## Title

Adult major depressive disorder (MDD): percentage of patients aged 18 years and older with a diagnosis of MDD who had a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.

## Source(s)

American Medical Association-convened Physician Consortium for Performance ImprovementÂ® (PCPIÂ®). Adult major depressive disorder performance measurement set. Chicago (IL): American Medical Association (AMA); 2015 Sep. 40 p. [18 references]

# Measure Domain

## Primary Measure Domain

Clinical Quality Measures: Process

## Secondary Measure Domain

Does not apply to this measure

# Brief Abstract

## Description

This measure is used to assess the percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) who had a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.

## Rationale

Research has shown that more than 90% of people who kill themselves have depression or another diagnosable mental or substance abuse disorder (Conwell & Brent, 1995). Depression is the cause of over two-thirds of the reported suicides in the U.S. each year (Depression and Bipolar Support Alliance, 2010). The intent of this measure is for a clinician to assess suicide risk at initial intake or at visit in which depression was diagnosed. As the guidelines state, it is important to assess for additional factors which may increase or decrease suicide risk, such as presence of additional symptoms (e.g., psychosis, severe

anxiety, hopelessness, severe chronic pain); presence of substance abuse, history and seriousness of previous attempts, particularly, recent suicidal behavior, current stressors and potential protective factors (e.g., positive reasons for living, strong social support), family history of suicide or mental illness or recent exposure to suicide, impulsivity and potential for risk to others, including history of violence or violent or homicidal ideas, plans, or intentions, and putting one's affairs in order (e.g., giving away possessions, writing a will). In addition, although the measure focuses on the initial visit, it is critical that suicide risk be monitored especially for the 90 days following the initial visit and throughout major depressive disorder (MDD) treatment.

The following evidence statements are quoted verbatim from the referenced clinical guidelines. Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

A careful and ongoing evaluation of suicide risk is necessary for all patients with MDD. (American Psychiatric Association [APA], 2010)

Such an assessment includes specific inquiry about suicidal thoughts, intent, plans, means, and behaviors; identification of specific psychiatric symptoms (e.g., psychosis, severe anxiety, substance use) or general medical conditions that may increase the likelihood of acting on suicidal ideas; assessment of past and, particularly, recent suicidal behavior; delineation of current stressors and potential protective factors (e.g., positive reasons for living, strong social support); and identification of any family history of suicide or mental illness. (APA, 2010)

As part of the assessment process, impulsivity and potential for risk to others should also be evaluated, including any history of violence or violent or homicidal ideas, plans, or intentions. (APA, 2010)

The patient's risk of harm to him- or herself and to others should also be monitored as treatment proceeds. (APA, 2010)

Guidelines for Selecting a Treatment Setting for Patients at Risk for Suicide or Suicidal Behaviors (APA, 2003):

*Admission Generally Indicated*

After a suicide attempt or aborted suicide attempt if:

- Patient is psychotic
- Attempt was violent, near-lethal, or premeditated
- Precautions were taken to avoid rescue or discovery
- Persistent plan and/or intent is present
- Distress is increased or patient regrets surviving
- Patient is male, older than age 45 years, especially with new onset of psychiatric illness or suicidal thinking
- Patient has limited family and/or social support, including lack of stable living situation
- Current impulsive behavior, severe agitation, poor judgment, or refusal of help is evident
- Patient has change in mental status with a metabolic, toxic, infectious, or other etiology requiring further workup in a structured setting

In the presence of suicidal ideation with:

- Specific plan with high lethality
- High suicidal intent

*Admission May Be Necessary*

[In addition to the list above, these additional circumstances may warrant admission]

After a suicide attempt or aborted suicide attempt:

In the presence of suicidal ideation with:

Major psychiatric disorder
Past attempts, particularly if medically serious
Possibly contributing medical condition (e.g., acute neurological disorder, cancer, infection)
Lack of response to or inability to cooperate with partial hospital or outpatient treatment
Need for supervised setting for medication trial or electroconvulsive therapy (ECT)
Need for skilled observation, clinical tests, or diagnostic assessments that require a structured setting
Lack of an ongoing clinician-patient relationship or lack of access to timely outpatient follow-up
[Evidence of putting one's affairs in order (e.g., giving away possessions, writing a will)]

In the absence of suicide attempts or reported suicidal ideation/plan/intent but evidence from the psychiatric evaluation and/or history from others suggests a high level of suicide risk and a recent acute increase in risk.

*Release from Emergency Department with Follow-up Recommendations May Be Possible*

After a suicide attempt or in the presence of suicidal ideation/plan when:

Suicidality is a reaction to precipitating events (e.g., exam failure, relationship difficulties), particularly if the patient's view of situation has changed since coming to emergency department
Plan/method and intent have low lethality
Patient has stable and supportive living situation
Patient is able to cooperate with recommendations for follow-up, with treater contacted, if possible, if patient is currently in treatment

*Outpatient Treatment May Be More Beneficial Than Hospitalization*

Patient has chronic suicidal ideation and/or self-injury without prior medically serious attempts, if a safe and supportive living situation is available and outpatient psychiatric care is ongoing.

## Evidence for Rationale


American Medical Association-convened Physician Consortium for Performance ImprovementÂ® (PCPIÂ®). Adult major depressive disorder performance measurement set. Chicago (IL): American Medical Association (AMA); 2015 Sep. 40 p. [18 references]

American Psychiatric Association. Practice guideline for the assessment and treatment of patients with suicidal behaviors. Arlington (VA): American Psychiatric Association; 2003 Nov. 183 p. [846 references]

American Psychiatric Association. Practice guideline for the treatment of patients with major depressive disorder. Arlington (VA): American Psychiatric Association; 2010 Oct. 152 p.

Conwell Y, Brent D. Suicide and aging. I: Patterns of psychiatric diagnosis. Int Psychogeriatr. 1995 Summer;7(2):149-64. PubMed

Depression and Bipolar Support Alliance. Facts about depression. [internet]. [accessed 2010 Nov 22].


## Primary Health Components

Major depressive disorder (MDD); suicide risk assessment

## Denominator Description

All patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) (see the related "Denominator Inclusions/Exclusions" field)

## Numerator Description

Patients with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified (see the related "Numerator Inclusions/Exclusions" field)

# Evidence Supporting the Measure

## Type of Evidence Supporting the Criterion of Quality for the Measure

A clinical practice guideline or other peer-reviewed synthesis of the clinical research evidence

A formal consensus procedure, involving experts in relevant clinical, methodological, public health and organizational sciences

One or more research studies published in a National Library of Medicine (NLM) indexed, peer-reviewed journal

## Additional Information Supporting Need for the Measure

Importance of Topic

*Prevalence and Incidence*

Major depressive disorder (MDD) affects approximately 14.8 million American adults, or about 6.7% of the U.S. population aged 18 and older in a given year (National Institute of Mental Health [NIMH], 2010).
While MDD can develop at any age, the median age at onset is 32 (NIMH, 2010).
MDD is more prevalent in women than in men (NIMH, 2010).
Depressive disorders are more common among persons with chronic conditions (e.g., obesity, cardiovascular disease, diabetes, asthma, arthritis, and cancer) and among those with unhealthy behaviors (e.g., smoking, physical inactivity, and binge drinking) (Centers for Disease Control and Prevention [CDC], 2010).

*Disability*

MDD is the leading cause of disability in the U.S. for ages 15 to 44 (NIMH, 2010).

*Suicide*

Research has shown that more than 90% of people who kill themselves have depression or another diagnosable mental or substance abuse disorder (Conwell & Brent, 1995).
Depression is the cause of over two-thirds of the 30,000 reported suicides in the U.S. each year (Depression and Bipolar Support Alliance, 2010)
The suicide rate for older adults is more than 50% higher than the rate for the nation as a whole. Up to two-thirds of older adult suicides are attributed to untreated or misdiagnosed depression (Depression and Bipolar Support Alliance, 2010).

*Disparities*

Non-Hispanic blacks, Hispanics, and non-Hispanic persons of other races are more likely to report major depression than non-Hispanic whites, based on responses to the Patient Health Questionnaire 8 (PHQ-8), which covers eight of the nine criteria from the Diagnostic and Statistical Manual of

Mental Disorders, Fourth Edition (DSM-IV) for diagnosis of major depressive disorder (CDC, 2010). For individuals who experienced a depressive disorder in the past year, 63.7% of Latinos, 68.7% of Asians, and 58.8% of African Americans, compared with 40.2% of non-Latino whites, did not access any mental health treatment in the past year (Alegría et al., 2008).

*Special Populations: Geriatrics*

The rate of depression in adults older than 65 years of age ranges from 7% to 36% in medical outpatient clinics and increases to 40% in the hospitalized elderly (Mitchell et al., 2013). Comorbidities are more common in the elderly. The highest rates of depression are found in those with strokes (30% to 60%), coronary artery disease (up to 44%), cancer (up to 40%), Parkinson's disease (40%), and Alzheimer's disease (20% to 40%)](Mitchell et al., 2013).
Similar to other groups, the elderly with depression are more likely than younger patients to underreport depressive symptoms (Mitchell et al., 2013).

Opportunity for Improvement

Hepner and colleagues (2007) found that primary care physicians (PCPs) assess for suicide only 24% of the time in patients with depression. In the same study, only 28% of PCPs adhered to the quality indicator "Treatment for suicidal ideation among patients not already followed in mental health care" (Hepner et al., 2007). McGlynn and colleagues (2003) found that only 25.8% of PCPs document the presence or absence of suicidal ideation during the first or second diagnostic visit. The same study showed that only 28.9% of patients who have suicidality and have any of the following risk factors: psychosis, current alcohol or drug abuse or dependency, and specific plans to carry out suicide (e.g., obtaining a weapon, putting affairs in order, making a suicide note) are hospitalized (McGlynn. et al., 2003). Additionally, Luoma and colleagues (2002) found that 40% of patients who completed suicide had seen their primary care physician in the past month.

## Evidence for Additional Information Supporting Need for the Measure


AlegrÃa M, Chatterji P, Wells K, Cao Z, Chen CN, Takeuchi D, Jackson J, Meng XL. Disparity in depression treatment among racial and ethnic minority populations in the United States. Psychiatr Serv. 2008 Nov;59(11):1264-72. PubMed

American Medical Association-convened Physician Consortium for Performance ImprovementÂ® (PCPIÂ®). Adult major depressive disorder performance measurement set. Chicago (IL): American Medical Association (AMA); 2015 Sep. 40 p. [18 references]

Centers for Disease Control and Prevention (CDC). Current depression among adults---United States, 2006 and 2008. MMWR Morb Mortal Wkly Rep. 2010 Oct 1;59(38):1229-35. PubMed

Conwell Y, Brent D. Suicide and aging. I: Patterns of psychiatric diagnosis. Int Psychogeriatr. 1995 Summer;7(2):149-64. PubMed

Depression and Bipolar Support Alliance. Facts about depression. [internet]. [accessed 2010 Nov 22].

Hepner KA, Rowe M, Rost K, Hickey SC, Sherbourne CD, Ford DE, Meredith LS, Rubenstein LV. The effect of adherence to practice guidelines on depression outcomes. Ann Intern Med. 2007 Sep 4;147(5):320-9.

Luoma JB, Martin CE, Pearson JL. Contact with mental health and primary care providers before suicide: a review of the evidence. Am J Psychiatry. 2002 Jun;159(6):909-16. PubMed

McGlynn EA, Asch SM, Adams J, Keesey J, Hicks J, DeCristofaro A, Kerr EA. The quality of health care delivered to adults in the United States. N Engl J Med. 2003 Jun 26;348(26):2635-45. PubMed

Mitchell J, Trangle M, Degnan B, Gabert T, Haight B, Kessler D, Mack N, Mallen E, Novak H, Rossmiller D, Setterlund L, Somers K, Valentino N, Vincent S. Adult depression in primary care. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2013 Sep. 129 p. [334 references]

National Institute of Mental Health (NIMH). The numbers count: mental disorders in America. [internet]. Chicago (IL): National Institute of Mental Health (NIMH); [accessed 2010 Nov 22].

## Extent of Measure Testing

The American Medical Association-convened Physician Consortium for Performance Improvement (PCPI) collaborated on a testing project in 2012 to ensure the *Adult Major Depressive Disorder (MDD) Suicide Risk Assessment* measure is reliable and evaluated for accuracy of the measure numerator and denominator case identification. The testing project was conducted utilizing electronic health record data. Parallel forms reliability was tested. Three sites participated in the parallel forms testing of the measure. Site A was a regional extension center comprised of a network of community health centers with 4,065 providers. Site B was a physician-owned private practice in an urban setting. Site C was a non-profit community mental health center with 5 psychiatrists, 30 therapists and 4 nurse practitioners.

Measures Tested

Adult Major Depressive Disorder (MDD) - Suicide Risk Assessment

Reliability Testing

The purpose of reliability testing was to evaluate whether the measure definitions and specifications, as prepared by the PCPI, yield stable, consistent measures. Data abstracted from electronic health records were used to calculate parallel forms reliability for the measure.

Reliability Testing Results

Parallel Forms Reliability Testing (Site A, B and C)

There were 120 observations from three sites used for the denominator analysis. The kappa statistic value of 0.80 demonstrates substantial agreement between the automated report and reviewer.

Of the 120 observations that were initially selected, 117 observations met the criteria for inclusion in the numerator analysis. The kappa statistic value of 0.37 demonstrates fair agreement between the automated report and reviewer.

Reliability: N, % Agreement, Kappa (95% Confidence Interval)

Denominator: 120, 99.17%, 0.80 (0.40, 1.00)
Numerator: 117, 66.67%, 0.37 (0.20-0.53)*

*This is an example of the limitation of the Kappa statistic. While the agreement can be 90% or greater, if one classification category dominates, the Kappa can be significantly reduced (http://www.ajronline.org/cgi/content/full/184/5/1391 ).

## Evidence for Extent of Measure Testing

American Medical Association-convened Physician Consortium for Performance ImprovementÂ® (PCPIÂ®). Adult major depressive disorder performance measurement set. Chicago (IL): American Medical Association (AMA); 2015 Sep. 40 p. [18 references]

# State of Use of the Measure

## State of Use

Current routine use

## Current Use

not defined yet

# Application of the Measure in its Current Use

## Measurement Setting

Ambulatory/Office-based Care

Behavioral Health Care

## Professionals Involved in Delivery of Health Services

not defined yet

## Least Aggregated Level of Services Delivery Addressed

Individual Clinicians or Public Health Professionals

## Statement of Acceptable Minimum Sample Size

Does not apply to this measure

## Target Population Age

Age greater than or equal to 18 years

## Target Population Gender

Either male or female

# National Strategy for Quality Improvement in Health Care

## National Quality Strategy Aim

Better Care

## National Quality Strategy Priority

Making Care Safer
Prevention and Treatment of Leading Causes of Mortality

# Institute of Medicine (IOM) National Health Care Quality Report Categories

## IOM Care Need

Getting Better

Living with Illness

## IOM Domain

Effectiveness

Safety

# Data Collection for the Measure

## Case Finding Period

Unspecified

## Denominator Sampling Frame

Patients associated with provider

## Denominator (Index) Event or Characteristic

Clinical Condition

Encounter

Patient/Individual (Consumer) Characteristic

## Denominator Time Window

not defined yet

## Denominator Inclusions/Exclusions

Inclusions
All patients aged 18 years and older with a diagnosis of major depressive disorder (MDD)

AND

Diagnosis for MDD (refer to the original measure documentation for International Classification of

Diseases, Ninth Revision, Clinical Modification [ICD-9-CM] codes [reportable through 9/30/2015])
Diagnosis for MDD (refer to the original measure documentation for International Classification of Diseases, Tenth Revision, Clinical Modification [ICD-10-CM] codes [reportable beginning 10/1/2015])

AND

Current Procedural Terminology (CPT) codes for encounter (refer to the original measure documentation for CPT codes)

Exclusions
None

## Exclusions/Exceptions

not defined yet

## Numerator Inclusions/Exclusions

Inclusions
Patients with a suicide risk assessment* completed during the visit in which a new diagnosis or recurrent episode was identified.

*Suicide risk assessment must include questions about the following:

Suicidal ideation
Patient's intent of initiating a suicide attempt
AND, if either is present,
Patient plans for a suicide attempt
Whether the patient has means for completing suicide

*Report G Code*: G8932: Suicide risk assessed at the initial evaluation.

Exclusions
Unspecified

## Numerator Search Strategy

Fixed time period or point in time

## Data Source

Administrative clinical data

Electronic health/medical record

## Type of Health State

Does not apply to this measure

## Instruments Used and/or Associated with the Measure

Unspecified

# Computation of the Measure

## Measure Specifies Disaggregation

Does not apply to this measure

## Scoring

Rate/Proportion

## Interpretation of Score

Desired value is a higher score

## Allowance for Patient or Population Factors

not defined yet

## Standard of Comparison

not defined yet

# Identifying Information

## Original Title

Measure #2: adult major depressive disorder (MDD): suicide risk assessment.

## Measure Collection Name

AMA/PCPI Adult Major Depressive Disorder Physician Performance Measurement Set

## Submitter

American Medical Association - Medical Specialty Society

## Developer

Physician Consortium for Performance ImprovementÂ® - Clinical Specialty Collaboration

## Funding Source(s)

Unspecified

## Composition of the Group that Developed the Measure

Work Group Members Adult Major Depressive Disorder

Work Group Members

Richard Hellman, MD, FACP, FACE (*Co-Chair*) (endocrinology, methodology)
John S. McIntyre, MD, DFAPA, FACPsych (*Co-Chair*) (psychiatry, methodology)
Alan A. Axelson, MD (psychiatry)
Stanley Borg, DO (family medicine)
Andrea Bostrom, PhD, PMHCNS-BC (nursing, psychiatric nursing)
Gwendolen Buhr, MD, MHS, CMD (geriatrics)
Katherine A. Burson, MS, OTR/L, CPRP (occupational therapy)
Mirean Coleman, MSW, LICSW, CT (social work)
Thomas J. Craig, MD, MPH, DLFAPA, FACPM (psychiatry)
Allen Doederlein (patient representative)
Molly Finnerty, MD (psychiatry, methodology)
William E. Golden, MD, FACP (internal medicine)
Jerry Halverson, MD (psychiatry, methodology)
Paul R. Keith, MD (health plan representative)
Clifford K. Moy, MD (psychiatry)
John M. Oldham, MD (psychiatry)
Shaunte R. Pohl, PharmD, BCPS (pharmaceutical science)
Mark A. Reinecke, PhD (psychology)
Leslie H. Secrest, MD (psychiatry)
Carl A. Sirio, MD (critical care medicine, methodology)
Sharon S. Sweede, MD (family medicine)
Roberta Waite, EdD, APRN, CNS-BC (psychiatric nursing, methodology)

Work Group Staff

*American Psychiatric Association*: Robert Plovnick, MD, MS; Robert Kunkle, MA; Samantha Shugarman

*American Medical Association*: Mark Antman, DDS, MBA; Katherine Ast, MSW, LCSW; Keri Christensen, MS; Kendra Hanley, MS; Karen Kmetik, PhD; Molly Siegel, MS; David Marc Small, MS, MPP; Kimberly Smuk, BS, RHIA; Samantha Tierney, MPH; Greg Wozniak, PhD

## Financial Disclosures/Other Potential Conflicts of Interest

None of the members of the Adult Major Depressive Disorder Work Group had any disqualifying material interests under the PCPI Conflict of Interest Policy. For a summary of non-disqualifying interests disclosed on Work Group Members' Material Interest Disclosure Statements (not including information concerning family member interests), refer to the original measure documentation.

## Endorser

National Quality Forum - None

## NQF Number

not defined yet

## Date of Endorsement

2014 Feb 28

## Measure Initiative(s)

Physician Quality Reporting System

## Adaptation

This measure was not adapted from another source.

## Date of Most Current Version in NQMC

2015 Sep

## Measure Maintenance

Unspecified

## Date of Next Anticipated Revision

Unspecified

## Measure Status

This is the current release of the measure.

This measure updates a previous version: Physician Consortium for Performance Improvement. Adult major depressive disorder physician performance measurement set. Chicago (IL): American Medical Association (AMA); 2010 Sep. 28 p.

## Measure Availability

Source available from the American Medical Association (AMA)-convened Physician Consortium for Performance Improvement® Web site .

For more information, contact AMA at 330 N. Wabash Avenue Suite 39300, Chicago, Ill. 60611; Phone: 312-800-621-8335; Fax: 312-464-5706; E-mail: consortium@ama-assn.org.

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## Copyright Statement



# Production

## Source(s)

American Medical Association-convened Physician Consortium for Performance ImprovementÂ® (PCPIÂ®). Adult major depressive disorder performance measurement set. Chicago (IL): American Medical Association (AMA); 2015 Sep. 40 p. [18 references]

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